

Testimony Concerning the Governor's Budget

Distinguished Members of the Appropriations Committee;

My name is Edward Schreiner. I am a resident of 36 Pineridge Drive, Oakville, Ct. I have owned and operated Stoll's Pharmacy in Waterbury, Ct since 1988. I am also the Chairman of the Board of Directors for Northeast Pharmacy Service Corporation, a company that provides business development services to approximately 250 community pharmacies throughout New England.

I am writing this letter to voice my opposition to provisions within the Governor's proposed budget that address pharmacy reimbursement for the Medicaid program. The Governor's Budget calls for \$76.3 Million dollars in savings (actually spending reduction) in pharmacy. This budget reduction is accomplished by slashing brand name drug reimbursement from AWP – 14% to 18%. What the proposal fails to acknowledge is that as a result of a lawsuit in September of 2009, the federal court decided that the definition of AWP would be rolled back by approximately 3.5% to 4% for most brand name medications. While Medicaid's drug reimbursement is defined using AWP, pharmacies do not buy drugs based on an AWP formula. We purchase our drugs based on a formula called Wholesale Acquisition Cost (WAC). WAC was not adjusted by the 2009 federal lawsuit. This resulted in an untenable position for pharmacies. While our cost to acquire drugs did not change, the rollback in AWP reduced our reimbursement for those very drugs by 4%. All prescription drug plans in Connecticut, other than Medicaid, acknowledged the problem and adjusted contracted reimbursement rates downward by an appropriate amount to maintain the differential between AWP and WAC. As an example, the Connecticut State Employee contracted rate was AWP – 17% prior to September 2009. After the AWP rollback was implemented pharmacy reimbursement was adjusted to AWP- 13.55%, thus maintaining the same differential between drug cost and plan reimbursement for the State Employee Prescription Drug Program.

In September of 2009, Connecticut's Department of Social Services did not adjust payments to providers for the Medicaid program (as all other plans did) to reflect the new definition of AWP. The effect was an immediate reduction in brand reimbursements to pharmacies from the "Published" rate of AWP -14% to the "actual" rate of AWP – 17.5%. This same reimbursement policy is in still in effect today. I have determined that this reduction in reimbursement in brand name drugs, when combined with the 2009 reductions in state generic drug list pricing, reduces reimbursement to my business by \$110,000 ANUALLY. The Governor's current budget proposal calls for another 4% reduction in brands to AWP-18%. Considering that this definition of AWP disregards the 3.5% AWP rollback of 2009, the actual rate being paid to pharmacy will be AWP – 21.5%. Despite being in a buying group with 250 other pharmacies in New England, I am not able to buy brand name drugs at a rate that would ensure I would remain profitable under this proposal. The Governor's budget proposal also calls for a decrease of \$1.40 in the dispensing fee for every prescription and a further reduction in generic drug reimbursement by 18%.

The Governor's budget also proposes reinstituting a patient copay on Medicaid prescriptions at \$3 per prescription that is capped at \$20/month (after the first seven prescriptions are filled each month). Unlike the commercial sector, pharmacies cannot withhold the medication from a Medicaid patient if they cannot pay, or refuse to pay the copay. In fact, when Medicaid copays last existed in 2003 and 2004, a Medicaid advocacy group gave numerous Medicaid recipients a laminated card that stated that "I AM UNABLE TO PAY THE \$1.00 COPAY TODAY" and "Refusing to fill a prescription or to provide services is a VIOLATION OF FEDERAL LAW". As a

result, most Medicaid recipients were keenly aware that they would receive their medication by simply stating their inability to pay. With no direct incentive for the Medicaid recipient to pay, my pharmacy was experiencing a payment refusal rate of over 50% by the time the copay requirement ended in 2004. Assuming that this trend will continue, when the \$3 copay goes unpaid, the proposed dispensing fee of \$1.50 turns into a cost of \$1.50 that must be absorbed by all pharmacies participating in the Medicaid program.

A national cost of dispensing study done in 2007 reported that it costs the average pharmacy (not just independent pharmacy but all pharmacies including chain stores and mass merchandising stores with pharmacies) \$12 to fill a prescription in Connecticut. I can guarantee that the cost of doing business is higher in Connecticut today than it was in 2007. Medicaid costs are actually more than that; patients can refuse the copayment, there are more claim rejection problems than with any other plan, and audits are extrapolated over two years of claims thereby exposing pharmacies to potentially huge financial penalties that arise out of unintentional clerical errors.

The drastic financial burden caused by reimbursement at (or below) pharmacy acquisition cost, combined with a dispensing fee nowhere near \$12 will disproportionately impact pharmacies located in certain urban areas. The pharmacies that provide the most care will not be able to continue filling Medicaid prescriptions. Being located in downtown Waterbury, the Medicaid program accounted for more than 30% of the prescriptions filled at my pharmacy in 2010. When all of the governor's pharmacy proposals are combined, the drastic drop in reimbursement will make filling 30% of my prescriptions unprofitable. My business location makes it difficult, if not impossible, for me to discontinue accepting Medicaid and find new customers in other plans. As reported in the 2010 NCPA Digest, the average community pharmacy generates 93.3% of its sales from prescription drugs. With only 6.7% of sales coming from non-prescription items, it will be impossible for most urban stores to continue accepting Medicaid and remain profitable so many pharmacies will very likely close.

Northeast Pharmacy Service Corporation estimates that about 30 independent community pharmacies in their 250 store network will be at risk of closure in communities like Bridgeport, Waterbury, Meriden, and some areas of Hartford and New Haven if these proposals are implemented. We would expect that profitability of chain pharmacies located in these same areas would be similarly affected under these proposals. Chain Pharmacies are not financially obligated to act in the best interest of the Medicaid program. They are publicly traded corporations whose primary responsibility is to maximize shareholder value. The decision to keep a store located in an urban setting open and subsidize the loss of income from that store with profits generated by other chain locations is strictly a business decision. After the independent closings or voluntary disenrollment from the Medicaid program, displaced Medicaid recipients doing business with the independents would have no alternative but to migrate to the chains. We cannot say whether the chains would then close. We can only say that their operation would be unprofitable unless they stopped accepting Medicaid prescriptions or negotiated a new, more profitable agreement with the state in light of the lack of competition from independent pharmacies.

Stating the obvious, by accepting the governor's budget proposals:

- The state would lose tax revenues and jobs as numerous pharmacies close.
- Access for Medicaid patients would suffer.

- There will be a void of service for those with special needs.
- Pharmacy doesn't realistically have more to give via reimbursement rate reductions; as my \$100,000 example proves, we are already giving.

Draconian cuts are not necessary. Drug prices aren't the problem. Pharmacy profits aren't the problem. The problem is that we are paying for the wrong drugs. I believe that DSS should be instructed to work with pharmacies in Connecticut to help control the budget for prescription drugs for Medicaid patients. Using lower cost generics is an important strategy for managing Medicaid drug costs. Medicaid should partner with community pharmacy to improve generic dispensing rates in their program, however, our Governor is proposing to lower generic reimbursement. This is a very short-sighted proposal. By lowering generic reimbursement the plan discourages pharmacists from helping increase the generic dispensing rate. Other states, such as North Carolina, have seen their generic utilization rates increase significantly by enhancing the dispensing fees paid to pharmacists to promote movement from brand to generic utilization. North Carolina pharmacists were able to help improve their state generic dispensing rate by approximately 8% in the first year of their program. Their state determined that moving generic utilization by 1% created \$20 million in savings! As you can see, **by partnering with pharmacists and supporting their activities, the state of North Carolina is able to create \$160 MILLION in savings ANNUALLY.**

In Connecticut, the Medicaid budget can be significantly reduced in a sustainable fashion by maximizing generic dispensing. The goal for generic dispensing should be as close as possible to 75%. When comparing the size of the North Carolina Medicaid program with Connecticut, we estimate that a 1% change in generic dispensing saves nearly \$10 Million. In 2009, according to the Generic Pharmaceutical Association, Connecticut's Medicaid program only achieved generic dispensing of 63% (7th from last in the country). Without taking a nickel from pharmacies, huge potential savings are on the horizon when Medicaid works in collaboration with its community pharmacy partners.

In conclusion, I strongly urge you to oppose approval of the Governor's proposed budget for the numerous, serious reasons I have presented today. Simply reducing reimbursement to pharmacies has not solved the pharmacy cost issues of the Medicaid program for the last 20 years. The prescription drug line item in the budget has increased steadily for 2 reasons; increased cost of the drug product and increased utilization by Medicaid recipients. As a taxpayer I ask you to instruct the Department of Social Services to work with Connecticut's pharmacists to find better, more innovative ways to control prescription drug spending for the Medicaid population, as the state of North Carolina has done, without jeopardizing Connecticut jobs, tax revenue and pharmacy access for Connecticut's most fragile patient population.

Thank you for the opportunity to express my opinion.

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